Benchmark IVb.2.1: Standardize RN home visitation, practice standards, and policies.
Evidence of Completion: Summary report of standards identified and issued policies

Name: _____

Start Date: _____

Registered Nurse
Orientation Competency Checklist –Ongoing Care

Orientation to the child welfare out-of-home nurse role is exciting and challenging. The BMCW Medical Director, BMCW Nurse Administrator, Agency Supervisor, Nurse Supervisor, and Community Partner Mentors/Preceptors are prepared to assist you in your orientation to this specialized nursing environment. They will assist with your training and give you a wide variety of experiences during your orientation.

Your orientation will consist of two components: Training Academy classes and mentored experiences. The Training Academy classes will give you the basic concepts and knowledge specific to the child welfare arena. Mentored experiences will assist you in learning to perform your job responsibilities and provide validation of your competency in your role.

There is much to learn and to do in the next several weeks/months. We have provided the people and the tools to help you begin to learn your role within child welfare.

You, however, are the most important person in determining your success in the orientation process.

Expectations for completing this document:

1. Review the skill list weekly during your orientation with your mentor/preceptor.
2. Have your mentor/preceptor sign off competencies as you complete them.
3. **Upon completion of orientation** this packet is to be given to the **Nurse Administrator** at the Bureau of Milwaukee Child Welfare.

Method Assessment:

A = Direct observation of practice
B = Simulation/Skills lab
C = Case Study
D = Discussion
E = Post test
F = Other

**** All items marked with an ** indicate competencies that must be completed to be off orientation.**

All ** items have been completed.

Signature: _____ Date: _____

Leader: _____ Date: _____

I understand and have completed the attached competency based orientation.

Signature: _____ Date: _____

Leader: _____ Date: _____

Preceptor Signatures:

_____ _____ _____ _____

_____ _____ _____ _____

INDEX

Page

GENERAL INFORMATION

GENERAL INFORMATION	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTOR INITIALS
****Work Unit** Locate assigned work space: • Telephone-Voice mail • Computer access • E-mail • Employee mailbox • Employee Break Room / conference room / bathrooms • Business Cards	A	**Must Do:** ☐ Region Introductions ☐ Meet with Information Technology		
****Supplies** • Home visitation supplies • Stock supplies • Office supplies ****Staff Kitchen/Break Room** • Microwave • Refrigerator • Vending Machines	A	**Must Do:** ☐ Obtain and Stock Nurse Home Visitation Bag		
****Health Unit Specific Information** Verbalize understanding of: • Case assignment • Out-of-home care visits • Health Unit rounds • Medical Director contact information • Nurse Administrator contact information • BMCW staff directory - Client. teaching materials & storage /resource library • Medical Director & Nurse Administrator offices	A			
****Identifies Available Resources** • BMCW Policy and Procedures on line • Health Unit Resource Materials • Health Unit assessments -Learning Nurse -Health modules • Annual Education/Competency checklist • Cultural Diversity textbook	A	**Must Do:** ☐ Complete Health Unit Assessments as indicated ☐ Put your Education/ Competency Checklist in the Health Unit binder write in your BLS expiration date and RN license expiration date.		

GENERAL INFORMATION

GENERAL INFORMATION - CONTINUED	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
**Identify and meet with the following people and become familiar with their roles/how they can assist you: • BMCW Medical Director_____ • • BMCW Nurse Administrator_____ • • Agency Director_____ • • Agency Supervisor_____ • • Nurse Consultants_____ • • Nurse Supervisor_____ • • Office Support staff _____	D	**Must Do:** ☐ Enter Names of the people in the first column.		
**Identify and meet with the following people and become familiar with their roles/how they can assist you: • CPC Manager_____ • • VNA Nursing Director_____ • • Child Advocacy Social Worker_____ • • CHW Social Services Manager_____ • • Penfield Coordinator_____ • • Meta House Director_____ • • SATC Nurse Manager_____ • DHC Nurse Manager_____	D	**Must Do:** ☐ Enter names of the people in the first column.		

****Become familiar with the following roles within child welfare how they function:** • Access:_____ • • Access Supervisor_____ • Initial Assessment: _____ Service manager_____ Region manager_____ Program Evaluation Manager_____ Program Assistant_____ • Ongoing Case Manager_____ • • Ongoing Case Supervisor _____ • • Program Manager _____ • • Safety Services Manager_____ • Safety Services Supervisor_____ • • Other_____	D	**Must Do:** ☐ Meet/introduction to a staff member in each role.		

ASSESSMENT WNL

**Demonstrates how to do a HEAD-to-TOE assessment based on WNL standards: *	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTOR S INITIALS
General Appearance • Appears calm/relaxed, demonstrates absence of physical discomfort. Smooth state regulation • Tolerates assessment/interaction/ stimulation/ activity-no apparent distress				
Neurological/Mental State • Alert, state of consciousness appropriate for age, cry, tone, reflexes appropriate for gestational or chronological age • Facial symmetry; absence of seizures, tremors, posturing • Fontanels WNL (up to 24 months)				
Musculoskeletal • Moves all extremities equally • Gross motor movement age appropriate				
Mobility/Postures appropriately for age • Able to tolerate activities and cares • Unrestricted and coordinated (age appropriate)				
Cardiac • HR/BP within age specific parameters; pulse: regular rhythm • No murmur				
Peripheral/Neurovascular • Adequate peripheral perfusion, CRT brisk, <2 seconds • Absence of vascular bleeding , edema				
Respiratory • Normal pattern; regular rhythm; rate within age parameters; symmetrical chest expansion; effort: quiet/easy; absence of pallor, cyanosis				
GI • Abdomen soft, non-distended, active bowel sounds • Absence of vomiting and/or blood in stool or vomit. • Stools soft, appropriate for age				
GU • Genitalia normal for gestational age and gender				
Integumentary • Warm dry and intact, color normal for race; mucous membranes pink/moist, eyes clear • No bruises, scrapes, injuries noted • Size color location of birth marks noted • Body mapping completed				
Nutrition/Hydration • Intake & type appropriate for age • Tolerating diet/feedings				
Continuity of Care • Caregiver verbalize or demonstrate the knowledge, skills, and/or behaviors necessary to meet infant/child needs • Caregiver understanding of health plan of care & follow up				
Spiritual/Valuing/Patient Rights • Caregiver indicates that values, beliefs & confidentiality are respected. Privacy needs are met • Caregiver states they have received information/support facilitate their involvement in healthcare planning and follow up				
Parent/Caregiver Education • Assess current level of knowledge and learning needs; readiness to learn, learning style and motivation				

Method of Assessment:
This entire section should be assessed via direct observation of practice.

Suggested Learning activities:
-Skills resources
-Policy and Procedures - Assessment videos
-Attend Nursing Orientation

Date completed a head-to-toe assessment:

_____

Preceptor/Mentors Initials: _____

Comments: patient age, dx, hx and how the orientee performed)

Child Safety • Child free of injury; absence of fever or other s/s of infection; standard precautions in place; • Developmental safeguards in place.	

BIOLOGICAL SYSTEMS

	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES AN INITIAL AND ONGOING PHYSICAL ASSESSMENT ON A NEONATE/INFANT/TODDLER. A. Physical Assessment 1. Performs a head to toe exam to include all biological systems plus. Head, eyes, ears, nose, throat, and mouth. 2. Performs assessment within 30 days of entering out-of-home care. 3. Performs assessment according to standard schedules and prn.	A	• Health Unit Training. • CPC in-service/practicum. • Learning Nurse self-study learning packets. • Child Advocacy In-services		
B. Gestational Age (as applicable). 1. Performs a gestational age assessment using physical and neuromuscular characteristics. 2. Accurately weighs and measures neonate/infant correcting for gestational age.				
C. Effectively cares for a neonate/young infant to maintain a neutral thermal environment. 1. Monitors temperature Axillary 2. Verbalizes clinical manifestations of hypothermia. • Organizes care/assessment to prevent states contributing to hypothermia.				
D. Demonstrate use of: • Thermometer • Tape measure-OFC and length				

BIOLOGICAL SYSTEMS

RESPIRATORY FOCUSED ASSESSMENT	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
A. Recognizes abnormal respiratory observations • Tachypnea • Grunting • Flaring • Retractions • Cyanosis	A	• Health Unit Training. • CPC in-service/practicum. • Learning Nurse self-study learning packets. Child Advocacy In-services		
B. Recognizes abnormal respiratory findings • Wheezes • Decreased breath sounds • Rhonchi • Stridor	A			
C. Verbalizes care specific concerns related to altered respiratory status/diagnosis: • Asthma • Chronic Lung disease • Oxygen dependence • Respiratory Syncytial Virus				

BIOLOGICAL SYSTEMS

CARDIAC FOCUSED ASSESSMENTS	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
A. Demonstrates understanding of abnormal cardiac findings. • Identifies abnormal heart sounds -Murmur -Irregular rhythm -Bradycardia -Tachycardia • Assesses for selected cardiovascular findings. -Skin color -Capillary refill time -Edema -Precordial activity • Determines presence and quality of pulses upper and lower extremities.	A	• Health Unit Training. • CPC in-service/practicum. • Learning Nurse self-study learning packets. Child Advocacy In-services		
B. Verbalizes specific concerns for an infant/child with altered cardiac states. -Congenital heart defects -Congestive heart failure -Other	D			

BIOLOGICAL SYSTEMS

GASTROINTESTINAL FOCUSED ASSESSMENT	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES THE ABILITY TO PERFORM A GASTROINTESTINAL ASSESSMET. A. Demonstrates understanding of a GI assessment including: 1. Performs an abdominal assessment. a. Auscultates bowel sounds b. Identifies shape of abdomen • Identifies abdominal distention and differentiates severity of it. c. Notes condition of umbilical cord (if applicable). 2. Recognizes abnormal stools. 3. Recognizes normal elimination pattern.	A, D	• Health Unit Training. • CPC in-service/practicum. • Learning Nurse self-study learning packets. Child Advocacy In-services		
B. Demonstrates proper care of children with a gastrostomy tube. • Assess G –tube site • Assess G- tube dressing • Reviews delivery of medications via the G tube	A,D			

BIOLOGICAL SYSTEMS

NEUROLOGICAL FOCUSED ASSESSMENT	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES THE ABILITY TO PERFORM A NEUROLOGICAL ASSESSMENT. A. Demonstrates understanding of neurological assessment including: 1. Performs an accurate neurologic assessment. 2. Differentiates abnormal neurologic activity related to immaturity. 3. Recognize abnormal reflexes. 4. Identifies anterior and posterior fontanels (age appropriate) 5. Recognizes normal/abnormal tone. 6. Measures and plots OFC		• Health Unit Training. • CPC in-service/practicum. • Learning Nurse self-study learning packets. Child Advocacy In-services		
B. Verbalizes specific care concerns for a child with compromised neurologic status. 1. Seizures. 2. Hydrocephalus. 3. Internal shunt or s/p external shunt 4. Myelomeningocele.				

BIOLOGICAL SYSTEMS

MUSCULOSKELETAL FOCUSED ASSESSMENT	METHOD OF ASSESS.	LEARNING ACTIVITES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES THE ABILITY TO PERFORM A MUSCULOSKELETAL ASSESSMENT. A. Demonstrates understanding of a musculoskeletal assessment including: • Extremities • Spine • ROM • Deformity • Contractures	A	• Health Unit Training. • CPC in-service/practicum. • Learning Nurse self-study learning packets. • Child Advocacy In-services		
B. Notifies PMD of noted deficits and need for evaluation.	A, D			
C. Birth to Three Referral	A, D			
D. Casts • Care education • Medical follow up	A, D			

BIOLOGICAL SYSTEMS

INTEGUMENTARY FOCUSED ASSESSMENTS	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
IDENTIFY THE COMPONENTS OF A SKIN ASSESSMENT AND BODY MAPPING. A. Verbalizes understanding of the definition and frequency a skin assessment must occur.	A, D	• Health Unit Training. • CPC in-service/practicum. • Learning Nurse self-study learning packets. • Child Advocacy In-services		
B. Recognizes normal skin variations.	A			
C. Recognizes abnormal skin characteristics. • Color • Texture • Turgor • Presence of lesions, rashes, bruising, ulcers, abrasions, petechiae, burns, skin tears, bites, patterned injuries • Incisions: No redness, ecchymosis, edema, unusual drainage, unapproximated edges. •	A			
D. Verbalizes understanding of skin care products and their uses. Demonstrates ability to provide education on care specific infant and child hygiene. 1. Newborn care 2. Bathing 3. Diapering 4. Toileting				
D. Verbalizes resources available to caregivers regarding care for altered skin integrity or specific diagnosis: • Eczema • Excessive dryness				
F. Verbalizes care specific management of a patient with an ostomy/ileostomy. • Skin Care – surrounding skin normal • Equipment needs • Medical follow up				

BIOLOGICAL SYSTEMS

MENTAL STATE FOCUSED ASSESSMENT	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
PROVIDES DEVELOPMENTALLY SUPPORTIVE NURSING CARE TO ALL NEONATES/INFANTS/TODDLERS. A. Assesses readiness to interact with the environment.	A/D	• Health Unit Training. • CPC in-service/practicum. • Learning Nurse self-study learning packets. • Child Advocacy In-services		
B. Identifies states of alertness.				
C. Positions infant to promote observation and assessment				
D. Provides appropriate environment for assessment • Lighting • Sound				
E. Observes caregiver holding appropriately.				
F. Provides for appropriate visual stimulation.				
G. Provides appropriate vestibular stimulation 1. Holding toys 2. ROM 3. Rocking infant				
H. Encourage caregiver to appropriately comfort child				
I. Verbalizes specific care concerns for a neonate undergoing withdrawal. 1. Use of (NAS) Neonatal Abstinence Scoring) 2. Weaning process				

BIOLOGICAL SYSTEMS

GENITOURINARY FOCUSED ASSESSMENT	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES THE ABILITY TO PERFORM A GENITOURINARY ASSESSMENT. A. Demonstrates understanding of a GU assessment	A, D	• Health Unit Training. • CPC in-service/practicum. • Learning Nurse self-study learning packets. • Child Advocacy In-services		
B. Identifies medical follow up needs related to abnormal anatomy • Hypospadius • Epispadius • Hydrocele • Ambiguous Genitalia				
C. Verbalizes care concerns for a child with impaired renal function. • Medical monitoring • Diet/restrictions as applicable				

STANDARD COMFORT/COPING

PAIN ASSESSMENT/MANAGEMENT	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES THE ABILITY TO ASSESS FOR THE CHILD IN PAIN. A. Demonstrates understanding of a basic comfort/coping assessment sense of discomfort: using standardized pain scales (e.g. Neonatal Infant Pain Scale (NIPS), FLACC, Wong FACES). 1. Change in vital signs 2. Facial expression 3. Cry 4. Position of limbs 5. State of arousal 6. Guarding 7. Splinting	A, B, D			
B. Identifies actions to take if pain is identified. 1. Consult PMD 2. Medical follow up (CPC/CHW ER)				
C. Assesses caregiver provision of comfort 1. Age appropriate techniques 2. Holding/rocking 3. Child response to caregiver intervention	A, D			

STANDARD NUTRITION/HYDRATION

STANDARD NUTRITION/HYDRATION	METHOD OF ASSESSMENT	LEARNING ACTIVITIES	DATE MET	PRECEPTOR INITIALS
INCORPORATES THE PRINCIPLES OF PROPER NUTRITION INTO NURSING PRACTICE. A. Verbalizes/demonstrates understanding of physiologic needs of nutrition. 1. Caloric needs 2. Nutritional supplements 3. Infant formula preparation		• Dietitian • WIC Nutrition Standard		
B. Assesses adequacy of nutritional intake				
C. Assess and plot weight in pounds and kilograms				
D. Verbalizes patient risk factors which would indicate a need to communicate concerns to MD. 1. Weight loss 2. No measurable weight gain in infant				
E. Demonstrates correct use of scales. 1. Infant scale 2. Standing scale				

STANDARD NUTRITION/HYDRATION

ENTERAL NUTRITION	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES THE ABILITY TO CARE FOR THE PATIENT REQUIRING ENTERAL NUTRITION. A. Review methods of feeding. 1. Continuous 2. Intermittent		• Nutrition standard • Dietitian		
B. Reinforces caregiver education on care of tubes used for feeding: 1. Gastrostomy 2. PEG tube				
C. Verbalizes rationale for oral hygiene				
D. Verbalizes safe feeding practices for neonate/infant/toddler. 1. Proper positions during and after feeding. • Notes tolerance to feeding as applicable. 2. Bottle feeding • Verbalizes knowledge of appropriate formula preparation. • Recognizes and reinforces appropriate caregiver response to infant cues during feeding (sleepy, drooling, needs breathing break).				
E. Verbalizes care specific concerns related to child ability to suck/swallow.				
F. Verbalizes understanding of the nutritional needs of the older infant and toddler				
G. Reviews food selections with caregiver • Allergy trigger avoidance • Choking hazards				

STANDARD CONTINUITY OF CARE

PLAN OF CARE	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES THE ABILITY TO DEVELOP A PLAN OF CARE AND DOCUMENT IT. A. Reads Nursing Documentation policy.	A, D	• Nursing process standards • Documentation policy • Introduction to Outcomes Based Care Management • Health Unit Resources		
B. Plan of care and documentation will show evidence of the nursing process: 1. Initial patient assessment is completed within 30 days of entry into out-of-home-care. 2. Ongoing system specific reassessments based on established schedule and/or child needs 3. Every child will have an individualized health plan of care. The plan reflects: • Health status score • Health needs priorities and other identified needs • Expected outcomes • Interventions • Ongoing evaluation 4. Pathway documentation will include: • Expected outcomes that have been met • Any variances to the pathway • Child/caregiver/family teaching outcomes				
C. Participates in the admission of an infant into out-of-home-care. 1. Gathers information about the child history from appropriate sources. • PMD report • Nurse Consultant report. • Report from discharging hospital if appropriate. • Appropriate chart forms. • Parents. 2. Reviews pertinent health information/medical records • CPC Health Screen • Hospital discharge records • PMD records				
D. Demonstrates the ability to orient a caregiver and/or child family to out-of-home-care nurse visits 1. Participation in care management 2. Role of health unit 3. Informed consent 4. Home visit schedule. 5. Initiation of health unit records/documentation				
E. Appropriately uses health plan of care				
F. Incorporates caregiver/parent teaching into each home visit				
G. Plans for the transition or reunification of child throughout out-of-home-care placement. Planning and documentation will include. 1. Identification of anticipated medical follow up needs 2. Evidence of collaboration with family and other disciplines, as evidenced by referrals.				

• Other information pertinent to the child needs.				

STANDARD CONTINUITY OF CARE

COMMUNICATION	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES THE ABILITY TO COMMUNICATE WITH OTHER MEMBERS OF THE HEALTH UNIT – SBAR A. Communicates accurate and appropriate information regarding child	A, D.	• Interpreter list available • Culture & Nursing Care: A Pocket Guide		
B. Notifies PMD of identified changes in child assessment				
C. Updates BMCW Medical Director and Nurse Administrator appropriately.				
D. Utilizes developmental and age appropriate principles when interacting with child/family.				
E. Verbalizes chain of command and when/how to use.				
D. Recognizes barriers to communication: 1. Language, visual changes, speech problems, memory loss, disorientation, developmental level, etc. 2. Cultural and/or ethnic and religious backgrounds. 3. Identify resources available.				
E. Notifies PMD appropriately of identified concerns and recommended follow up				
F. Initiates and/or participates in multi-disciplinary care conferences as indicated.				
G. Demonstrates when and how to access an interpreter				

STANDARD PATIENT EDUCATION

STANDARD PATIENT EDUCATION	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
PROVIDES PATIENT/FAMILIES WITH THE NECESSARY EDUCATION TO FOSTER OPTIMAL CARE. A. Assess child/caregiver/family learning needs regarding care 1. Readiness/motivation to learn, which is influenced by: • Cultural/religious practices • Emotional barriers • Physical/cognitive limitations • Language barriers • Age specific needs 2. Teach or reinforce teaching as appropriate for caregiver/family. 3. Educational resources utilized.				
B. Verbalizes available teaching materials – includes Spanish.				
C. Incorporates teaching needs into plan of care.				
D. Collaborates with other disciplines as needed.				

STANDARD SAFETY

STANDARD: SAFETY	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES/VERBALIZES METHODS OF MAINTAINING SAFETY. A. Verbalizes criteria for identification of Suspected Victims of Abuse and Neglect.	A, B, D			
B. Demonstrates/identifies methods to ensure child safety:				
C. Verbalizes/identifies signs of child abuse.				
D. Verbalizes appropriate intervention(s) if abuse is suspected. • 220-SAFE referral				
E.				

STANDARD SAFETY

**INFECTION CONTROL	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
VERBALIZES/DEMONSTRATES UNDERSTANDING OF THE CONCEPTS OF INFECTION CONTROL. A. Verbalizes infection control practices and standard precautions				
B. Verbalizes differences and demonstrates compliance of various modes of transmission: 1. Standard precautions a. Verbalizes location of personal protective equipment (gloves) 2. Describes transmission-based spread of infection a. Airborne b. droplet c. contact				
C. Describes/demonstrates cleaning of equipment. 1. Cleans equipment between assessments (i.e. stethoscope, thermometer, etc.)				

CARE/CUSTOMER SERVICE

CUSTOMER SERVICE	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
DEMONSTRATES CAREGIVING PHILOSOPHY WHEN INTERACTING WITH CLIENTS AND COLLEAGUES		• Orientation Classes		
A. Recognizes needs of children/caregivers/families with a variety of mental and/or physical disorders.				
B. Communicates with respect and dignity toward all clients, co-workers and guests.				
C. Communication style demonstrates use of appropriate verbal and non-verbal skills and a caring attitude.				
D. Explains all procedures and activities to children and caregivers prior to performing them.				
E. Obtains necessary information from co-workers to provide care for assigned children.				
F. Recognizes symptoms of stress in families/caregivers, co-workers and self in coping behaviors.				
G. Recognizes limitations of own ability to care for clients.				
H. Introduces self to children/caregivers/families and identifies child prior to performing activities.				
I. Recognizes the need for self-growth to promote professional development.				
J. Promotes a professional image by adhering to established dress codes.				
K. Maintains privacy and confidentiality.				
L. Verbalizes the actions to take/resources available for: • Caregivers/families with a complaint • Coworkers with (at work) problems.				

**DOCUMENTATION	METHOD OF ASSESS.	LEARNING ACTIVITIES	DATE MET	PRECEPTORS INITIALS
A. Admission Nursing History Completes all of the components of a nursing history. •Child database within 30 days of entry into out-of-home-care. •Comprehensive head to toe assessment. •Risk assessments -Nutrition -Skin -Personal Safety •Develop a plan of care/pathway.	A	Must Do: ☐ Attend eWiSACWIS training.		
B. Ongoing Assessments Completes ongoing assessments based on child needs and home visitation standards. •Risk assessments (skin.) •Routine standards •Routine Teaching •All other care related activities (nutrition, activity, etc)	A			
C. Plan of Care/Pathway Develops a plan of care/pathway that is based on individual patient needs. •Identify actual or potential problems •Develop goals •Set interventions •Evaluate	A			
D. Transition Planning Planning and documentation will include: •Identification of anticipated needs. Evidence of collaboration with caregiver/family and other disciplines, as evidenced by referrals. •Discharge instructions will include: 1. Follow up instructions 2. Other information pertinent to the patient needs	A			
E. If using automated documentation systems: • Demonstrates procedure for accessing electronic records • Demonstrates procedure or printing of documents.	A			

Out of Home Care In-Home RN Evaluation

PATIENT NAME:
MRN:
DOB:
DATE OF EXAM:

Patient Label

Patient has been previously seen at Child Protection Center (CPC)? ☐ Unknown ☐ No ☐ Yes Date:

Ongoing Case Manager (OCM):	Child Lives With: Name/Relation	CURRENT PMD:

Last Medical Exam (if known): Date:	Last Dental Exam (if known): Date:

Temp:	Pulse:	Resp:	BP:

Height/Length: Cm %	Weight: Kg %	BMI	Head Circumference: Cm %

Reason for PLACEMENT/DETENTION:
☐**Neglect:** ☐Medical ☐General ☐**Abuse:** ☐ Physical ☐ Sexual ☐ **Other:**_____
Reason for Visit/Chief Complaint:
History of Present Illness/Interval History:

ALLERGIES (List Allergen and Reaction): ☐ **No Known Allergies**

MEDICATIONS: ☐ **No Medications**

☐ **Rx** ☐ **OTC Currently using:** ☐ **YES** ☐ **NO** ☐ **Out of Medication**
☐ **Rx** ☐ **OTC Currently using:** ☐ **YES** ☐ **NO** ☐ **Out of Medication**
☐ **Rx** ☐ **OTC Currently using:** ☐ **YES** ☐ **NO** ☐ **Out of Medication**
☐ **Rx** ☐ **OTC Currently using:** ☐ **YES** ☐ **NO** ☐ **Out of Medication**

PMH/SOCIAL HISTORY:	N0:	YES:	COMMENTS:
Hospitalizations/ Surgeries:	☐	☐	
Health Problems:	☐	☐	
Nutrition:	☐	☐	
Sleep:	☐	☐	
Elimination:	☐	☐	
Daycare:	☐	☐	

Ages of Other Children in current Home: **Biological:** **Foster:**

REVIEW OF SYSTEMS:	NEG	POS		NEG	POS
Weight Loss	☐	☐	Musc/Skel: Limp, Weight Bearing	☐	☐
Fevers	☐	☐	Skin: Bruises, Swelling, Rashes, Eczema	☐	☐
Eyes: Drainage, Abnormal Movements	☐	☐	Neurological: Seizures	☐	☐
ENT: Ear Pain, Throat Pain, Rhinorrhea	☐	☐	Psychiatric: Acting Out	☐	☐
Dental: Caries, Tooth Pain	☐	☐	Heme: Bleeding, Anemia, ↑Lead	☐	☐
Cardio: Cyanosis, Sweating while eating	☐	☐	Allergies or Reactions	☐	☐
Respiratory, URI, Wheeze, Cough, Distress	☐	☐	Unintentional Injury (Accidents):	☐	☐
GI: Vomiting, Diarrhea, Feeding Vigor	☐	☐	Other:	☐	☐

Describe all positive ROS findings not in HPI:

PHYSICAL EXAM:

GENERAL: ☐Active ☐Happy ☐Playful ☐Engaged ☐Withdrawn ☐Delayed

Movements: ☐ Rolls Over ☐ Sits ☐ Crawls ☐ Cruises ☐ Walks

Vocalizations: ☐ None ☐ Coos ☐ Babbles ☐ 2-3 Words ☐ 8-10 Words ☐ 10+

PT NAME:
RN:
DOB:
DOS:

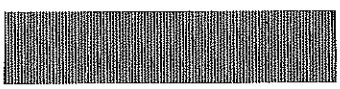
Patient Label

	NL:	ABN:	DOCUMENT ALL SIGNIFICANT FINDINGS:
EYES: Conjugate Gaze	☐	☐	
EOMI	☐	☐	
PERRLA	☐	☐	
Conjunctiva	☐	☐	
EARS: Shape and location	☐	☐	
Pinna: Anterior	☐	☐	
Pinna: Posterior	☐	☐	
Canal	☐	☐	
TM	☐	☐	
NOSE:	☐	☐	
MOUTH: Oral Hygiene	☐	☐	
Upper Labial Frenulum	☐	☐	
Lower Labial Frenulum	☐	☐	
Lingular Frenulum	☐	☐	
Buccal Mucosa:	☐	☐	
Dentition, if applicable	☐	☐	
THROAT:	☐	☐	
NODES:	☐	☐	
LUNGS:	☐	☐	
HEART:	☐	☐	
ABDOMEN: Bowel Sounds	☐	☐	
Non Distended	☐	☐	
Nontender/ No Guarding	☐	☐	
No Palp Hepatosplenomegaly	☐	☐	
GENITALIA: Anatomy	☐ **M**	☐ **F**	
Sexual Maturity Rating	☐ 1	☐ 2 ☐ 3 ☐ 4 ☐ 5	
No Acute trauma	☐	☐	
Free of Discharge/Odor	☐	☐	
Anus	☐	☐	
MUSCULOSKELETAL: (Includes Palpation and Joint ROM)			
Scalp	☐	☐	
Fontanel(s) (If present)	☐	☐	
Ribs	☐	☐	
Arm/Wrist	☐	☐	
Reaches with both arms	☐	☐	
Hand/Fingers	☐	☐	
Leg/Ankle	☐	☐	
Bears weight on both legs	☐	☐	
Foot/Toes	☐	☐	
NEUROLOGIC: Alert	☐	☐	
Muscle Tone	☐	☐	
Response to tactile stimuli	☐	☐	
SKIN: Includes Palms, Soles and Under Arms			(Use Body Diagram on next page to document any skin findings.)
No Rashes	☐	☐	
No Lacerations	☐	☐	
No Bruises	☐	☐	
No Bites	☐	☐	
No Burns	☐	☐	
No Scars	☐	☐	

PATIENT NAME:
MRN:
DOB:
DATE OF EXAM:

Patient Label

Body Diagram to be completed for documentation of skin assessment/findings on patient's body:



Out of Home Care
In-Home

PT NAME:
RN:
DOB:
DOS:

Patient Label

ASSESSMENT:

☐ **Health Status Score _____**

☐ **Health Needs Score _____**

☐ **Current Health Conditions/Issues (acute and chronic)**

1. _____
2. _____
3. _____
4. _____
5. _____

☐ **NO CONCERNS IDENTIFIED**

☐ **DEVELOPMENTAL/SOCIAL EMOTIONAL CONCERNS IDENTIFIED**
If yes, please include details below

☐ **HEALTH PROBLEMS IDENTIFIED/CONCERNS NOTED:**

1. _____
2. _____
3. _____
4. _____
5. _____

☐ **Indicators of Abuse Detected.**

- ☐ **Discussed with Ongoing Case Manager.**
- ☐ **Bureau of Milwaukee Child Welfare notified at (414) 220-SAFE.**
- ☐ **Child Advocacy consulted to discuss concerns.**

PLAN and RECOMMENDATIONS:

- ☐ **F/U with PMD** _____
- ☐ **UTD with Well Child Checks; Next Well Child Check Due** _____
- ☐ **Overdue for Well Child Check**
- ☐ **Needs Immunization Record verified and may need additional immunizations.**
- ☐ **Immunizations UTD**
- ☐ **Recommended Follow Up :** ☐ **Dental** ☐ **Behavioral Health** ☐ **Other:**

_____
_____
_____

- ☐ **Comments on Child, Family or other Specific Medical Issues :**

_____
_____
_____

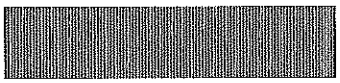
- ☐ **Home Medication List reviewed/updated.**

Health Education/Anticipatory Guidance (Check all completed)

☐ Development	☐ Appropriate Car Seat
☐ Safe Sleep	☐ Passive Smoke
☐ Nutrition/Feeding	☐ Child Care
☐ Infant/Toddler Temperament	☐ Language Stimulation
☐ Discipline/Limits	☐ Toilet Training
☐ Shaken Baby Syndrome	☐ Other _____

Signature:_____ **Date/Time:** _____
NURSE PRINT NAME

Signature:_____ **Date/Time:** _____
FOSTER PARENT, IF PRESENT PRINT NAME



eWiSACWIS HSOM Documentation

From Search:

1. Enter the Last Name and First Name or Case ID

2. Check the "Participant View" checkbox- this will automatically do a search for cases

3. In the Cases Returned group box, expand the Case icon for your case

4. Click the Actions hyperlink next to the participant for which you would like to create an assignment

5. On the Actions page, select the Create Assignment radio button and click Continue

6. On the Create Worker Assignment page, click on the appropriate Select hyperlink(s) of the worker(s) you want to assign the case participant to. If you do not see his/her name, go to the View By box and select County/State. On the left side of the screen will be a listing of all counties. Select the appropriate county and look for the name of the person you want to assign the case to. When identified, click on the Select hyperlink next to the worker's name. There is no limit as to the number of assignments you can create for a case participant.

7. On the bottom of the page is the Assignment Definition and Details box. Type, Responsibility, and Role are all drop down values. Select the appropriate value for the type of case assignment to be made for each worker. Remember, there can only be one Primary Assignment.

8. The Current Worker box indicates the name of the current worker assigned to the case. The Current Worker Status box relates to the assignment status of the current worker assigned to the case. If the assignment for the current worker should be closed, click the Close radio button and her assignment will close when the new worker is assigned to the case.
9. The Assignment Definition and Details box will pre-fill with the new worker assigned (Worker Name), the case name (For), the case participant (Participant), and the date the assignment was effective for (Start Date).
10. Once completed, click on the Assign button. eWiSACWIS will create a new assignment, close the current worker assignment (if selected), and notify all people assigned to the case of any change in case assignment via e-mail.

To Record HSOM

1. Go to eWiSACWIS Desktop (First page after log-in)
2. Click on the + sign in front of "Cases"
3. Click on the selected case FOLDER
4. Select the child and click on his/her nam
5. Select Characteristics Tab
6. Under HSOM select 'INSERT'
7. Enter date of score
8. Enter Status and Needs Scores via Dropdown menu

9. Select 'Save'
10. Select 'Close"
11. Record eWiSACWIS Casehead Number
12. Close Case Folder

To Close Assignment

13. At top of menu bar select 'SEARCH'
14. Enter Case ID
15. Uncheck 'Date Restricted' Box
16. Open Case Folder
17. Go to ASSIGNMENTS
18. Locate your name
19. Click on your name
20. Select "Closed" under Status
21. Select Save
22. Exit Case

Health Unit Documentation eWiSACWIS Case Note Tipsheet

Log onto eWiSACWIS

Click Search

Enter Casehead ID or name

Select Casehead

Click on ACTIONS (next to Casehead name)

Select Create Case note

Enter Date and Time of note

Select Creator-BMCW IA RN or Ongoing Care RN

Contact type (leave blank unless Face-to-Face with family members)

Contact Detail: If summarizing as Health Staffing, select "Health Staffing" If consulting, leave value empty- this is considered a case note not a comprehensive health record review

Health Staffing note details to include:

Child Name and DOB:

Staff present:

Reason for Health Staffing:

Health Status Outcome Measure (Health Status Score and Health Needs Scores):

Primary Healthcare Provider name:

Current Health conditions (diagnosed conditions):

Plan and Recommendations for Staff (select as applicable):

- Follow up with Primary Healthcare Provider: _____
- Up to date with Well Child Exams/ Next Well child Check Due: _____
- Overdue for Well Child Exam
- Needs Immunization record verified and may need additional immunizations
- Recommended Follow-up: Dental Behavioral Health Birth to Three
- Specialty Clinic Follow up Due: _____
- Obtain additional medical records from: _____
- Other: _____

Health Consultation Note details to include:

Child Name and DOB:

Staff present:

Reason for consult:

Health concerns:

Recommendations for staff:

Obtain EDS report

Request health records from: _____

Contact Primary Healthcare provider regarding: _____

Request Health Case Staffing when records are obtained

Actions taken by RN:

Contacted Primary Healthcare Provider

Contacted Milwaukee Public Health

Contacted Home Health Agency

Contacted CHW Specialty Clinic staff

Other: _____

Ongoing Care RN Home Visit note:

Child name:

Child DOB:

Reason for visit and location of visit: Initial RN home visit, 30 day home visit, 90 day home visit, interval home visit

Health Concerns identified: None or detail findings

Health Status Score:

Health Needs Score:

Current ht/wt/ ofc:

Next PMD appt:

Actions taken by RN: (select as appropriate)

Contacted Ongoing Case Manager

Contacted Child Advocacy staff

Contacted Primary Healthcare Provider

Contacted Milwaukee Public Health

Contacted Home Health Agency

Contacted CHW Specialty Clinic staff

Other: _____

Next Ongoing Care RN Home visit: date/time/location

** All nurse consult, health staffing, or RN home visit notes must be documented in eWiSACWIS within 2 business days.

** Health Unit Staffing form must be completed at time of Health Staffing

Sample Case Note Consult

9/13/2010

10:00 a.m.

BMCW RN

Child Name: Allison Doe

Child DOB: 9/11/10

Staff present: Akiko Pasewald and Rebecca Jacobi

Reason for Consult: Drug affected newborn concerns

Health Concern: 38 week gestation newborn, remains in NICU due to Neonatal Abstinence Syndrome (NAS). Maternal cocaine, opiates, and THC use in pregnancy. No prenatal care. Infant's urine drug screen positive for cocaine and opiates. Meconium screen is pending.

Recommendations for staff:

Request hospital birth records and NICU admission History and Physical from Aurora Sinai Medical Center

Request Health Case Staffing when medical records are obtained

Actions by RN:

Contacted Jan Brown, RN Aurora Sinai Medical Center NICU during health consultation to discuss Allison's neonatal abstinence syndrome scores and health status. Per Jan Brown, RN: Allison was started on morphine sulfate and Phenobarbital this morning for NAS weaning due to NAS scores of 12-15 for the last 24 hours.

Health Unit Staffing Form

Staffing Date:

Child Name:

Child DOB:

Staff present:

Reason for 220-SAFE referral:

Health concerns/ reason for staffing:

Current Health Conditions/Issues (acute and chronic)

1. _____
2. _____
3. _____
4. _____
5. _____

PMD:_____

Specialty Clinics:_____

Health Status Score: _____ **Health Needs Score:** _____

Case discussion/concerns:_____

PLAN and RECOMMENDATIONS (check all applicable):

- ☐ **F/U with PMD** _____
- ☐ **UTD with Well Child Checks; Next Well Child Check Due** _____
- ☐ **Overdue for Well Child Check**
- ☐ **Needs Immunization Record verified and may need additional immunizations.**
- ☐ **Immunizations UTD**
- ☐ **Recommended Follow Up :** ☐ **Dental** ☐ **Behavioral Health** ☐ **Birth to Three Referral**
- ☐ **Other follow-up: (Specialty clinics, IEP, etc. as recommended by medical record review)**

_____
_____
_____

- ☐ **Comments on Child, Family or other Specific Medical Issues :**

_____
_____
_____

Health Education/Anticipatory Guidance (Check all completed)

- ☐ Child development
- ☐ Infant Safe Sleep
- ☐ Nutrition/Feeding
- ☐ Passive Smoke Exposure
- ☐ Other _____

Additional comments:

Signature: _____ Date: _____

2011 Annual Competencies
Nurse Consultants
Ongoing Care Nurses

All registered nurses in child welfare practice have a responsibility to seek out and engage in ongoing education and professional development to maintain the competencies that are specific to nursing practice.

Management of care- Health Status Outcomes

- Carries out a comprehensive and accurate nursing assessment of individuals and groups in a variety of settings.
- Uses a structured approach in the process of assessment.
- Collects data regarding the health and functional status of individuals and groups.
- Analyzes and interprets data accurately.

Demonstrates proficiency in the use of information management technology and systems to inform clinical care management.

- Effectively uses administrative systems (i.e. Nurse Tracking Tool) designed to assist with the care of infants and toddlers
- Maintains clinical data system including health status/needs scores and consultation/staffing/visit notes.

Recognizes when to seek advice from the nurse practitioner and/or medical director about the care of individuals, families, and populations.
Examples may include:

- Seeks advice when the needs of individuals and groups are beyond own knowledge, skill, abilities and/or education;
- Understands the roles of the administrative health care team;
- Understands the roles of community agencies and service providers.

Successful completion of the aforementioned competencies is expected for all nurses working in child welfare. Competency packet must be completed and returned to Kathy Elertson by October 21, 2011.

Name: _____

Date: _____

Management of care- Health Status Outcomes

- Carries out a comprehensive and accurate nursing assessment of individuals and groups in a variety of settings.
- Uses a structured approach in the process of assessment.
- Collects data regarding the health and functional status of individuals and groups.
- Analyzes and interprets data accurately.

Health Status Outcome Measures

1. 3 week old DAI- THC positive, normal neonatal course, newborn exam and 2 week exam- no concerns, gaining 40 gms daily. RTC at 2 months.

   Status_____ Needs_____

2. 16 month old- right femur fracture, casted, repeat skeletal in two weeks, PMD in one month, Ortho clinic next week, under-immunized

   Status_____ Needs_____

3. 16 year old pregnant female, referred to OB, dental caries, under-immunized

   Status_____ Needs_____

4. 4 year old with asthma, incomplete immunizations, RTC monthly for asthma assessment, immunizations UTD

   Status_____ Needs_____

5. 12 year old referred to Emergency Medication Clinic for psychotropic medication assessment, wcc and immunizations UTD

   Status_____ Needs_____

6. 30 month old with cerebral palsy, g-tube dependent, non-mobile, no medical exams since 12 months of age, lost to follow-up, WIR-no data

   Status_____ Needs_____

7. 16 month old seen every two weeks by PMD for weight checks due to possible failure to thrive. Immunizations UTD

   Status_____ Needs_____

8. 15 year old with quadriplegia due to motor vehicle accident, immunizations up to date.

   Status_____ Needs_____

9. 34 week preemie DAI-methadone withdrawal, currently hospitalized

   Status_____ Needs_____

10. 7 week old with NAT, traumatic brain injury, intracranial hemorrhage, hospitalized no immunizations

    Status_____ Needs_____

Management of Care

- **Carries out a comprehensive and accurate nursing assessment of individuals and groups in a variety of settings.**
- **Analyzes and interprets data accurately.**

Go to the following website: http://learningnurse.com.
Select Test and Quiz Center from the column on the right
Click on Learning Nurse Tests and Quizzes

Complete the following tests:
3.1 Infection Prevention and Control Quiz
9.7 Childhood Diseases and Ailments Quiz
12.3 Pediatric Nursing Quiz

Print your completed quiz score and attach to this packet- you must attain a score greater than 84% to pass this competency

Name: _____

Date: _____

Demonstrates proficiency in the use of information management technology and systems to inform clinical care management.

- Effectively uses administrative systems (i.e. Nurse Tracking Tool) designed to assist with the care of infants and toddlers
- Maintains clinical data system including health status/needs scores and consultation/staffing/visit notes.

1. The Nurse Tracking form is sent to Holly Gamblin

   A. Monthly
   B. Bi-monthly
   C. On demand
   D. Annually

2. Health Status Outcome scores are entered on the Nurse Tracking Tool and eWiSACWIS

   A. On every child entering out-of-home care
   B. At every nurse visit for children over 6 months of age
   C. Quarterly
   D. All of the above

3. Nurses must assign themselves as 'participants' to a case in eWiSACWIS in order to enter HSOM.

   True False

4. Case notes must be entered in eWiSACWIS within _____ business days of a consult or visit.

   A. 1 business day
   B. 2 business days
   C. 3 business days
   D. 5 business days

5. Nurse logs and tracking tools are use as health metrics

   True False

Name: _____
Date: _____

Recognizes when to seek advice from the nurse practitioner and/or medical director about the care of individuals, families, and populations.

- Seeks advice when the needs of individuals and groups are beyond own knowledge, skill, abilities and/or education;
- Understands the roles of the administrative health care team;
- Understands the roles of community agencies and service providers.

1. A child with a higher level of medical complexity may be consulted or staffed by a child welfare nurse with Dr. Urban or Kathy Elertson.

   True False

2. A health plan of care should be created for any child entering out-of-home care

   True False

3. A health staffing note/nurse visit note must include diagnosed conditions

   True False

4. Every child entering out-of-home care must have an identified primary healthcare provider

   True False

5. Child welfare nurses are able to make referrals to specialty healthcare providers

   True False

6. Ongoing Care nurses need to monitor the status of any community health service providers (i.e. Birth to Three, Outpatient Therapy services, Home Health Agency)

   True False

7. 220-SAFE must be called for any child referred to CPC for a PA exam after a nurse visit and assessment

   True False

Nurse Family Engagement Annual Feedback

RN: _____ Agency: _____

Rationale: On-sight observation, ongoing communication and constructive feedback will enable Nurse Family Engagement nurses to reflect upon and refine their professional practice and contribute to the ability of child welfare staff to meet the health needs of infants and toddlers in out-of-home care.

Core Competency	Performance Expectations	Feedback
1. Assessment	Performs comprehensive assessments which include: health history, physical assessment, injury surveillance, assessment of growth, developmental and social-emotional monitoring as evidenced by direct observation of practice, completion of RN Out-of-Home Care assessment forms, growth chart recording and trending, and eWiSACWIS documentation. Assesses health status and health needs of children in out-of- home care as evidenced by completion of Health Status and Needs scoring and recording. Assesses and prioritizes need for referral(s) to primary health care provider or community services based on information gathered as reflected in RN Out-of-Home Care Assessment forms and eWiSACWIS documentation regarding health case planning. Documents assessment using established Health Unit records and documentation practices as evidenced by completion of RN Out-of-Home Care Assessment form, Health Unit records, and eWiSACWIS documentation within 3 business days of home visit. Consistently assesses risk factors for child abuse and neglect-medical and/or physical, and the effects of violence on the child through the following actions:	

	a. Identifies situations and conditions of the child, family, school, and community that put the child at risk for abuse/neglect. b. Identifies behavioral signs in the child that are associated with abuse/neglect. c. Recognizes injuries or exam findings which are concerning for inflicted trauma and/or neglect.	
2. Planning	Integrates knowledge of child needs and nursing interventions to design an individualized health plan of care that is consistent with standards of practice and established procedures as evidenced by eWiSACWIS documentation and related documentation regarding health case planning. Demonstrates prioritization of problems and issues based on assessment data as evidenced by creation of a problem list and health case planning. Utilizes evidence-based practice and critical thinking skills in decision making and health case planning.	
3. Evaluation	Provides health case management necessary for children to receive recommended health services and assesses for effectiveness of the interventions to meet the identified physical and mental health needs. Documents health case plan according to established practices as evidenced by review of RN Out-of Home Care Assessment form and eWiSACWIS documentation.	

4. Communication	Demonstrates communication skills that are clear; effective; facilitate Health Unit and team functioning. Listens respectfully and promotes effective communication with parents and caregivers Communicates effectively orally and in writing, including documentation, health file maintenance, case transfer process, and email correspondence. Establishes and maintains effective communication with case managers, families, caregivers, members of the Health Unit, and community health partners. Communicates thoroughly, promptly, and respectfully with agency and Health Unit leadership regarding health related case concerns.	
5. Cultural competence	Utilizes culturally sensitive and age appropriate methods for interacting effectively and professionally with persons from diverse cultural, socioeconomic, educational, racial, ethnic, and professional backgrounds, as well as persons of all ages and lifestyle preferences. Develops and adapts approaches to problems that take into account cultural values and differences.	
6. Collaboration	Demonstrates responsibility and accountability for practice including awareness of scope and parameters at all times. Establishes a professionally-based interpersonal relationship with caregivers or families that increases or enhances their capacity for effective	

	care. Establishes effective professional relationships with other members of the Health Unit. Participates in agency-based interdisciplinary teams to achieve health-related child outcomes Coordinates with community health and developmental resources for effective and informed child healthcare Demonstrates an understanding of the role of child welfare nurses in the delivery of community-based health service.	

Summary:

RN signature: _____ Date: _____

Revie
wer signature: _____ Date: _____

Out of Home Care Nurse Assessments

Reminders:

All children must have a weight check performed at each visit

Percentiles for height, weight, and OFC must be listed with the measurement

Notations made on the documentation for eWiSACWIS worksheet must be documented on the Out of Home Care Nurse Assessment form.

Current Health Conditions are medically diagnosed conditions

Health Problems Identified/Concerns noted are concerns the nurse finds during the visit

Interval Health History should list the known health history upon entering OOHC including any ED, PMD, Specialty visits since the last visit.

Next Well Child Check due should be listed-either list the appointment date or the next timeframe (e.g. 4/30/11 @ 2:15 pm or May for 6 month WCC)

All pages of the Nurse Exam including signature page and body mapping must be included in the files sent for review

Signatures of the Foster/Bio parent are to be obtained at each visit. If the foster parent is not available to sign, the OCM must sign

Ongoing Care Nurse Supplies

Digital Infant Scale with bag
Standing Scale for toddlers

Nurse Home Health Tote bag
Supplies for Tote bag:
*Paper measuring tapes
*Sanitary pre-moistened wipes (diaper wipes)
*Latex-free gloves
Penlight
Growth chart forms- Birth to 36 months for boys and girls
*Waterless hand sanitizer
*Germicidal spray
*Bleach wipe packets
*Paper towels
*Paper liners for scales
Bandage scissors
Health record clipboard
Cell phone
Pediatric stethoscope

To be kept in vehicle for emergencies:
Disposable CPR face shield
Emergency First Aid kit

*Will require replacement stock of these items to replenish supplies as needed

Digital thermometers need to be supplied to each child for monitoring of vital signs. They can be purchased in bulk inexpensively. JCAHO requirements prevent sharing of thermometers between homes.